Connecticut's Legislative Commission on Aging

A Nonpartisan Public Policy and Research Office of the Connecticut General Assembly

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Senator Flexer, Representative Serra and esteemed members of the Aging Committee, my name is Deb Migneault and I am the Senior Policy Analyst for Connecticut's Legislative Commission on Aging. As you know, Connecticut's Legislative Commission on Aging is the non-partisan, public policy and research office of the General Assembly, devoted to preparing Connecticut for a significantly changed demographic and enhancing the lives of the present and future generations of older adults.

Connecticut is the 7th oldest state in the nation with the 3rd longest-lived constituency, and between 2010 and 2040, Connecticut's population of people age 65 and older is expected to grow by 57%.

For over twenty years, our Commission has served as an effective leader in statewide efforts to promote choice, independence and dignity for Connecticut's older adults and persons with disabilities. We're grateful that several of the bills on the agenda today will help realize these efforts.

SB 162: An Act Concerning a Community Spouses Allowable Assets
~ CT's Legislative Commission on Aging Supports

CT's Legislative Commission on Aging's long held principle is to create a system ~ through a series of policies, programmatic and funding reforms ~ that allows people to receive services and support in the environment of their choice. We know that the predominate choice for older adults and persons with disabilities is the community. At the same time, we know that people may choose or require nursing home care at some point in their lives. When this happens, often couples will be divided as one partner may need the type of services that an institution provides while the other remains in the community. Clearly, we have an equal responsibility to the spouse living in the community. SB 162 would help ease their financial challenges of the "Community Spouse".

Although Connecticut's cost of living is one of the highest in the country, the state utilizes the most restrictive option for states, and only permits the Community Spouse (of a person on Medicaid in the nursing home) the lesser of one half of the couples assets or $119,220 but no less than $23,844. Forcing a spend-down to the minimum amount of $23,844 is in direct contradiction to the state and federal government's goals of helping keeping people in their homes as they age. This bill would set the protected amount to the maximum allowed under federal law $119,220 and would ease the burden of the community spouse who is trying to maintain independence at home with limited resources available to them.

Past proposals on this matter have generated fiscal notes with varying estimates. The Legislative Commission on Aging fully supports a full analysis of the true cost of raising the minimum protected amount. In 2010, legislation was passed allowing the community spouse to keep the maximum protected amount. However, claiming budgetary issues, the legislation was later rescinded and returned to the federal minimum. Unfortunately, hard data is not available to ensure accuracy of the budgetary estimates and many believe that the budgetary assumptions did not take into account the longer-term costs of the community spouse spending down assets more quickly and potentially needing Medicaid assistance earlier.

Additionally, our 2009 study "Elders Living on the Edge: Toward Economic Security for Connecticut's Older Adults", conducted in partnership with the Permanent Commission on the Status of Women, illustrates that many of Connecticut's older adults who are predominately relying on Social Security fall short of economic security. This economic security issue is most severe for older adult women. The current and most restrictive rule disproportionately affects women who statistically outlive their spouses. Support of this bill would demonstrate the state's commitment to "aging-in-place" and community living.

SB 164: An Act Concerning Medicaid Coverage of Telemonitoring Services
~ CT's Legislative Commission on Aging Supports

SB 164 would allow home health care agencies to collect reimbursement from Medicaid for home telemonitoring services provided to certain patients. Currently, at least 18 other states already provide Medicaid coverage for home telemonitoring services.[1] Telemonitoring allows for early detection of medical complications and lowers hospital admissions and readmissions.

The health care needs of the burgeoning population of older adults will rapidly outpace the ability of traditional models of health care delivery to adequately meet those needs. To maintain current rates of utilization, by 2030 Connecticut will 15% more primary care physicians than we have today.[2]

Telemonitoring, one category of telehealth services:

- **Improves health outcomes** as measured by improved medication adherence, reduced hospital readmissions, and a variety of other indicators. Its recordable nature also improves documentation and verification.
- **Saves individuals, providers and payers money**, compared with traditional approaches of providing care.
- **Offers a person-centered approach** as it empowers consumer choice, allows care to be provided where a patient is located, and provides flexibility.
- **Compliments and enhances the face-to-face care that home health provides**.

Medicaid coverage of telemonitoring has been recommended through various state plans and studies including the 2016 Long-Term Services and Support Plan and the Governor's Strategic Rebalancing Plan. Providing Medicaid coverage for teleleath/telemonitoring was also a recommendation of the Aging in Place Task Force (SA 12-6), Alzheimer's Disease and Dementia Task Force (13-11), and the Home Care Study (SA 14-6).

[1] American Telemedicine Association. State Telemedicine Gaps Analysis: Coverage and Reimbursement. September 2014
[2] CT Association for Healthcare at Home. 2015-2016 CT Medicaid Home Care Workgroup Recommendations. December 2015.

SB 165: An Act Expanding Eligibility for the Alzheimer's Disease Respite Care Program
~ CT's Legislative Commission on Aging Informs

The Respite Care Program provides a needed respite and support for caregivers of individuals with Alzheimer's disease and related dementias who remain in their homes and communities. Some estimate that those caregivers in Connecticut provide over $5.9 billion of unpaid care annually – and importantly, a higher quality of life to their spouses, neighbors, parents and friends. Connecticut caregivers are the foundation of our system of care yet, according to AARP's State Scorecard, Connecticut ranks 30th in nation for our support of caregivers.

The Long-Term Care Needs Assessment (conducted in 2006), the 2016 Long-Term Services and Supports Plan, the Governor's 2013 Strategic Rebalancing Plan and the Task Force on Alzheimer's Disease and Dementia (SA 13-11) all recommend providing enhanced supports to caregivers. Research clearly indicates that supporting caregivers with programs such as the CT Statewide Respite Care Program is critical to keeping individuals out of nursing homes. It also helps to maintain the health of the caregiver.

The bill before you broadens eligibility standards without commiserate funding. The impact of this could be that you reach more slightly higher income people, but with fewer dollars available overall per person.

Of further import, as you are aware, the Respite Care Program is not an entitlement; it is limited by its specific line item appropriation. The Governor's 2016 Mid-Term Budget Adjustments Proposal seeks to reduce funding by $130K. We encourage your support of maintaining the full appropriation for this program.

SB 166: An Act Expanding Utilization of Patient-Designated Caregivers
~ CT's Legislative Commission on Aging Supports

Through the leadership of this committee, last year the General Assembly passed the "CARE Act" (PA 15-32) which allows patients to designate a caregiver at or before the time the patient receives their discharge plan from a hospital and requires a hospital to 1) document the designated caregiver in the patient's discharge plan 2) attempt to notify the designated caregiver of the discharge and 3) instruct the caregiver on post-discharge tasks with which the caregiver will assist with at home. SB 166 would expand these requirements to nursing facilities. Connecticut's caregivers are an integral and frequently unrecognized part of the health care team. An estimated 460,000 people provide care to family members, friends and loved ones. Most people receive little to no formal care and rely entirely on unpaid caregivers to help them with these important daily tasks and medical care. However, the caregiver performing these tasks receives little or no training to do so. Offering a small amount of training prior to hospital or nursing facility discharge should be a required standard of care. However, not all elements of the original CARE Act are necessary (and relevant) for nursing facilities; the language of the bill may need to be amended to clarify intent and ease of understanding for nursing facilities.

SB 5283: An Act Restoring State Assistance for Medicare Part D Beneficiaries
~ CT's Legislative Commission on Aging Supports

HB 5283 seeks to reinstate the Medicare Part D co-pay wraparound assistance. While we understand the fiscal challenges of the state budget, we encourage you remain mindful of the elimination of this important wrap-around program while negotiating this and future budgets. As a matter of policy, data suggests that co-pays for this complex population will likely cause in an increase in physician and hospital visits thereby negating any potential savings.

By way of background, when Medicare Part D (Medicare Prescription Drug Program) was implemented, Connecticut created a "Wrap-Around" program. This program was created so that the state could maximize federal funding and individuals wouldn't receive less support with prescription drugs than they were already receiving under ConnPace (our state's former prescription drug program for older adults and persons with disabilities). The "wrap around" put a $15 cap on the amount "dually eligible" for Medicare and Medicaid (with the exception of those receiving home and community-based services under Medicaid) would pay for Part D-covered drugs. The state would cover any costs that exceed this amount, hence the "wrap-around".

As an example, if a person who is dually eligible for Medicare and Medicaid has 7 Medicare Part D covered prescriptions that each have a $5 co-pay, the total of the co-pays would be $35. With the state wrap-around coverage the person would have paid $15 and the state would have paid the remaining $20. With the elimination of the wrap-around coverage the enrollee is now responsible for covering the full $35. However, if the person is at the same income level and on Medicaid but not eligible for Medicare, they do not have to pay a co-pay.

The FY 2016-2017 State Biennium Budget eliminated the wrap-around that covered the cost of Medicare Part D covered drugs above the $15. The elimination of the co-pay was expected to save $90,000 in Fiscal Year '17.

There are 71,785 people who are dually eligible (minus 11,700 people who are on the CHCPE waiver) that this impacts.[3] Many of these adults are of both modest means and of poor health (on multiple prescriptions). The mean number of prescriptions filled per dual eligible beneficiary is 3.4. However, 14% of beneficiaries fill 7 or more prescriptions a month.[4] The co-payments per prescription range from $1.20 to $7.40 in 2016.

Further, this created an inequity as Medicaid-only individuals at the same income level, who have their drugs covered through Medicaid, continue to have no drug copays. The state's policy to pay for the co-pays for the Medicaid population is based on data that shows that it is far more cost effective to cover the cost of the co-pays because beneficiaries who cannot afford the co-pays may forgo filling necessary prescriptions increasing the likelihood of a more costly emergency room visit or hospital stay.

[3] CT Department of Social Services, CoA data request response compiled by CHNCT and JEN Associates. December 30, 2015.
[4] Schore, J., Brown, R., & Lavin, B. (2003). Racial Disparities in Prescription Drug Use Among Dually Eligible Beneficiaries. *Health Care Financing Review*,*25*(2), 77–90.

HB 5284: An Act Increasing Funding for Elderly Nutrition
~ CT's Legislative Commission on Aging Informs

The Elderly Nutrition Program (ENP) is an important program in supporting older adults in the community. It provides adequate nutrition critical to health, quality of life and overall functioning to older adults via congregate meals and home-delivered meals statewide. In 2015 almost 3.1 million meals were home-delivered and over 729,000 congregate meals were served across 188 congregate meal sites.

The ENP is primarily funded by federal and state dollars and partially funded by suggested contributions from participants and private donations. For the past several years, overall funding have remained flat. Unfortunately, flat funding translates into a decrease as the costs associated with this program keep rising markedly.

As a direct result, elderly nutrition providers are now forced to utilize a variety of approaches in response, such as putting caps on the number of meals served at sites, closing sites one or two days a week and not offering home delivered meals on weekends. It is important to note that unfortunately, it is a difficult cycle (a conundrum) ~ when fewer meals are served statewide, less money comes in from the federal government (as the federal government reimburses the state based on the number of meals served.

Clearly, the demand for the ENP will increase in concert with the soaring population of older adults and the major movement to keep people in the homes and communities. The last Cost of Living Adjustment (COLA) for home-delivered meals through the CT Home Care Program for Elders (CHCPE) was in 2007. Since then the Consumer Price Index has risen by 13%. According to the Connecticut Association of Nutrition Agency Service Providers, the program operated with a statewide gap between reimbursement from CHCPE and total cost of providing of $974,164 in 2015.

HB 5285: An Act Requiring the State Ombudsman to Investigate Complaints Concerning Recipients of Home and Community-Based Care
~ CT's Legislative Commission on Aging Informs

Mandated by the federal Older Americans Act, the LTCOP safeguards the rights and quality of life for residents of skilled nursing facilities, residential care homes and assisted living. This proposal would significantly expand the role and work of the LTCOP to also safeguard the rights of those living in their homes and communities. In the 2013 CGA session, PA 13-234 established a pilot in Hartford to have the LTCOP available in the community and appropriated funding. Some initial work had begun. However, the funds were not released due to the hiring freeze. The Fiscal Year 2016 and 2017 State Biennium Budget eliminated the funding for this effort ($28,015) and the enabling statutory language. It is important to note that the LTC Ombudsman does not have the capacity to staff a pilot or this new mandate without additional funds. Existing federal funds for the LTCOP are restricted and are not allowed to be used for community-based ombudsman services.

HB 5289: An Act Concerning Protective Services for Vulnerable Persons
~ CT's Legislative Commission on Aging Supports

Pursuant to Public Act 15-236, the Legislative Commission on Aging was charged with conducting a study concerning best practices for reporting and identification of abuse, neglect, exploitation and abandonment of older adults. After consulting with various state departments, including the Department of Social Services, the State Department on Aging, the Office of the Long-Term Care Ombudsman, the Department of Public Health and the Chief State's Attorney's office as well as the Elder Justice Coalition's Coordinating Council, and number of national experts, the Commission concluded its investigation and submitted its report to you on December 31st. The study includes a comprehensive look at national and state policies that impact elder abuse. The study further describes the roles and relationship among the many Connecticut intervention partners – most struggling with capacity issues – who work to address elder abuse, offer protective services, promote the rights of older adults, conduct investigation, prosecute crimes, collect and develop promising practices. The report includes 15 recommendations to further prevent, detect and intervene on issues of abuse, neglect, exploitation among older adults and persons with disabilities. Four of the recommendations from the study are before you today in the form of a four part piece of legislation, as follows:

Section 1 requires DSS to develop a strategic plan to (1) incorporate the Administration for Community Living's (ACL) Voluntary Consensus Guidelines for State Adult Protective Services into protective services for adults sixty years of age and older offered in the state, and (2) align state data collection with the National Adult Maltreatment Reporting System.

The ACL has facilitated the development of these guidelines with the goal of promoting an effective APS response system across all states. As ACL's Voluntary Consensus Guidelines are developed for an adult protective services model (18+ year of age), Connecticut will have to adapt the guidelines to fit Connecticut's current elderly protective services model. ACL is also developing NAMRS, the data collection data set is currently being piloted in 11 states.

Section 2 requires DSS to develop a training program to be made available on their website for mandated reporters and other interested parties.

This online training module for mandated reporters should include role of PSE, elder abuse red flags and reporting procedures to PSE. A similar training module is mandated in statute for DCF for child protective services mandated reporters. Additionally, financial agents are required to have training on elder financial abuse through a portal developed on the Legislative Commission on Aging's website (pursuant to PA 15-236 and within available appropriations). Financial agents are NOT mandated reporters but required to have training. However, mandated reporters are not required to have training and do not have similar access to training.

Section 3: Requires the Department of Social Services to formalize a system for follow-up with the person who filed the initial report to Protective Services for the Elderly (PSE). This will help to ensure that post-investigative follow-up occurs consistently and uniformly for all reports. Once PSE completes its investigation of a complaint, the person who filed the report is notified of the findings. Under current law, such follow-up occurs only upon request.

Section 4: Requires the Legislative Commission on Aging to complete a comprehensive evaluation of the state's protective services system for elderly persons and make recommendations concerning whether the state should adopt a protective services system serving persons eighteen years of age and older.

Connecticut is one of very few states in the nation that does not utilize an adult protective services model, which serves adults who are 18 years of age and older. Rather, Connecticut's PSE program only serves adults who are age 60 years of age or older. The Office of Protection and Advocacy for Persons with Disabilities is limited to serving individuals with developmental disabilities currently served by the Department of Developmental Services. We believe an objective evaluation of the possibility of moving to an adult protective services model in necessary.

Further Background

Data on the prevalence and severity of elder abuse is limited, owning largely to two factors. First, the lack of uniformity in both definitions of elder abuse and data collection method makes extrapolation difficult. Second, the vast majority of elder abuse cases go unreported. Though cases of elder abuse remain vastly underreported, the number of reports and investigations has been increasing steadily in recent years. There are no national data on the trends in the number of elder abuse cases reported. But according to a survey administered by the U.S. Government Accountability Office (GAO) in 2009, 31 responding states collectively received 357,000 reports of elder abuse, and 33 responding states collectively conducted 292,000 investigations. Based on projected population growth among older adults alone, elder abuse investigations in states studied may increase by 28 percent by 2020 and 50 percent by 2030.[5]

These estimates are likely conservative for Connecticut, where the growth of the older adult population is occurring more rapidly than in the rest of the country. Connecticut is the 7th oldest state in the nation, based on median age. It also has the third longest-lived constituency, with an average life expectancy of 80.8 years for residents born in Connecticut today. More than one-third of Connecticut's population is over the age of 50, and that proportion continues to rise. Between 2010 and 2040, Connecticut's population of people age 65 and older is projected to grow by 57%, with less than 2% growth for people age 20 to 64 during the same period.[6]

Connecticut's Protective Services for the Elderly Program (PSE), administered by the Department of Social Services, is designed to safeguard older adults from physical, mental and emotional abuse, neglect (including self-neglect), abandonment and financial abuse and exploitation by investigating and responding appropriately to reports of elder abuse. Connecticut is one of only very few states in the nation that does not utilize an adult protective services (APS) model, which serves adults ages 18 and older. Rather, PSE only serves those adults who are 60 years of age and older. [7]

Connecticut's challenge with an aging population and increasing caseloads is consistent with the

[5] Government Accountability Office. Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse (March 2011). GAO-11-208. <http://www.gao.gov/assets/320/316224.pdf>

[6] Connecticut's Legislative Commission on Aging. Community Livability in Connecticut (July 2015). http://coa.cga.ct.gov/images/pdf/LivableCommunities2015AnnualReportFINAL.pdf

[7] Administration on Aging. National Center on Elder Abuse. http://www.ncea.aoa.gov/Stop_Abuse/Partners/APS/index.aspx

experience of other states. The number of referrals to Connecticut's Protective Services for the Elderly Program (PSE) increased by almost 28% between 2010 and 2014, and the number of investigations increased from 3,529 to 4,764 over the same time period.[8] Importantly, PSE cases comprise just over 50% of social workers' caseloads in Social Work Services, which includes but is not limited to PSE.

Staff and Caseload	2011	2012	2013	2014	2015
Social Workers	83	83	76	78	76
PSE Cases Served	3529	3604	4024	4764	5679

We are thankful for empowering us to conduct this study and raising the bill before you today.

HB 5291: An Act Concerning Senior Centers
~ CT's Legislative Commission on Aging Supports

In 2011, the Connecticut Association of Senior Center Personnel in collaboration with CT's Legislative Commission on Aging surveyed senior centers across the state in order to better understand the range of services provided, funding and staff support of Connecticut's senior centers. The study (Profile of Senior Centers in Connecticut) found that among the 100 centers who responded to the survey the budgets, staffing levels, services offered, availability of training, hours of operation, etc., senior centers across Connecticut are extremely diverse. For example, in 2011 the median operating budget for senior centers was between $231,000 and $1.5 million.

Senior Centers, Municipal Agents, Resident Services Coordinators, Social Service Departments and many other municipal entities are often foundational elements of our services and supports system, particularly as it relates to information and referral. The Department of Social Services has received $72 million dollars from the Center for Medicare and Medicaid Services (CMS) through the Balancing Incentive Program (BIP) to develop the infrastructure necessary to support uniform access and streamlined processes for individuals seeking long-term services and supports (LTSS). A component of this initiative is No Wrong Door approach to services by offering multiple points of contact for those seeking LTSS information: online, over the phone and in person. Certainly, senior centers and municipal agents (as well the other entities mentioned above) should be key among the vast stakeholder network in the development of this system.

During the legislative process last year, this bill was amended to take out the participation of the state agencies on this task force. We respectfully encourage you to leave the state agencies on the task force this year. Their participation in these discussions is necessary and

[8] Connecticut Department of Social Services' Protective Services for the Elderly Program. Enhancement of Connecticut's Protective Services for the Elderly: Program Effectiveness and Efficiency. Project Narrative (2015).

important without which the task force would be less effective in putting forward actionable recommendations.

We support the bill before you and look forward to task force recommendations on how to best to integrate senior centers and municipal agents into informational and referral systems.